THE PULSE
SPRING 2009
THE OFFICIAL NEWSLETTER OF THE LOS ANGELES COUNTY FIRE DEPARTMENT EMERGENCY MEDICAL SERVICES PROGRAM

At the Heart of Quality Improvement

by Kristina Hajjar

When Liz Budek graduated from the Los Angeles County Medical Center School of Nursing in 1990, her first job as a registered nurse was literally steps away as a member of the bustling emergency room team at the nation's largest public hospital. In 1997, she stepped across town to join the Dodgers baseball organization to coordinate a team of nurses, treating fans, players, and Dodger employees. But now, she's signed on with the nation's largest paramedic team as the Los Angeles County Fire Department's new Senior EMS Program Head, looking to improve another L.A. landmark: our world-renowned Emergency Medical Services Program.

The New Quality Improvement Committee met at headquarters on March 20, 2009. Pictured in the front row (l-r): Senior Nursing Instructor Linda Brumfield, Ocean Lifeguard Specialist Danielle Pollard, Dr. Franklin Pratt, QI Program Director Liz Budek, Battalion Chief Anthony Whittle and EMS Administrator Victoria Hernandez. Middle row (l-r): Fire Captains Patrick Dolan, Dave Morse and Steven Swiatek, Issue Resolution Coordinator Margie Chidley, Fire Fighter Paramedic Scott Robinson, Fire Fighter Specialist Phil Rivera and Fire Fighter Paramedic Joe Coffey. Back row (l-r): Fire Captain Ray Garcia, Supervising Fire Dispatcher Ed Pickett, Fire Fighter Paramedic Shawn Motes and Secretary III Espie Sanchez. Committee members not pictured: Education Program Director Evie Anguiano, Senior Nursing Instructor Toni Arellano, Fire Fighter Paramedic Rob Artle, Fire Captain Jeff Britton, Fire Fighter Paramedic Abraham Serrano and Senior Nursing Instructor Sara Stamback. Ad hoc members not present include Fire Captains Jim Keehn and Paul Lombardo.

Budek joined the Department's EMS Section last September as Quality Improvement (QI) Program Director, following an eight-year stint as a clinical nurse specialist at Harbor-UCLA Medical Center in Torrance. As paramedics prepare to mark four decades of life safety service, Budek's new role also brings challenge and change to a not-so-new profession.

"My job is to measure and figure out ways to make things better – without attributing blame," she said. "We need to create a system to prevent errors from happening, to help our firefighters perform better as paramedics."

As a former instructor in the County's Paramedic Training Institute, Budek understands the firefighting culture and admits that creating a new atmosphere of learning is asking for a shift in perception.

"I want to promote a culture of improvement by incorporating best practices, improving the overall process, preventing errors and improving the quality of care that we provide to our patients," she explained.

Budek emphasized that it is everyone's job to improve the Department's QI process and overcome our natural inclination to be "creatures of habit" and overlook the need for change. One way she plans to do that is to take a look at the data to see where our needs really are, working with other recently-hired EMS program managers and the Department's network of battalion-based nurse educators.

"Our senior nursing instructors will be an integral part of it all and be able to help identify some of the problems. We will all look at the numbers," she said. "While they see what is happening in their battalions, I will be looking at it from a global perspective."

One best practice that is a top priority for Budek is documentation. One example is the 814 criteria used in the field by paramedics to determine patient death. Budek will be looking at every single cardiac arrest case, including those that met the 814 criteria, to make sure that it was

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At the Heart of Quality Improvement

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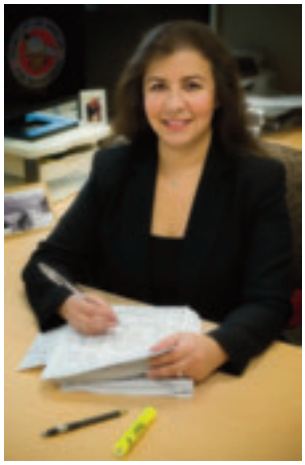


Senior EMS Program Head Liz Budek, the Department's new Quality Improvement Program director, at her office in Commerce.

followed correctly. One of her tasks is to look at all documentation on these cases – literally hundreds of them – which must be pulled by hand and verified.

"Our firefighters really need to understand that the documentation must be complete and legible so that the verification may be completed and timely feedback on their performance can be provided. Overall, they want to know how they're doing in the field," she said.

Another best practice Budek plans to incorporate is to work closely with the education program director to ensure that the education is quality improvement-driven.

The QI Program will improve patient care through the timely feedback to paramedics in the field and the Department's chief decision makers to create a continuous improvement process within the organization.

"The patient must be at the heart of our efforts," says Budek. "Patients demand quality care and our firefighters should realize they're part of the team. I'm also looking to them for ideas to help us figure out what the problems are and by looking at them as a system."

One way Budek plans to help revamp the QI Program is to establish a QI Committee, a working group with members tasked with bringing information and solutions. Initially, the group will include two to three representatives from each of the Department's three regions, one from Air Operations, one from Lifeguards and one from Training, plus four senior nursing instructors, the Paramedic Coordinators, the EMS Battalion Chief, and the Medical Director. Further plans include the addition of a representative from each of the Department's 21 battalions.

"I'm already getting phone calls from field paramedics, which I welcome," says Budek, who plans to convene the committee either quarterly or every other month beginning in March.

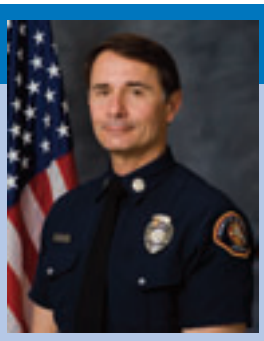
Budek learned about the position from other nurses within the prehospital arena and was ready for a new chapter in her 21-year County career.

"I'm interested in QI in particular and knew that it would be a good, challenging position," she says. "Sometimes we need new eyes to see what is needed."

***Liz Budek** graduated from the Los Angeles County Medical Center School of Nursing as a Registered Nurse in January 1990. She continued on in her education at California State University, Los Angeles, graduating in 1996 with a Master of Science degree in Nursing as an Emergency/Trauma Clinical Nurse Specialist. Just prior to joining the Fire Department, Liz worked for seven years as a clinical nurse specialist at Harbor-UCLA Medical Center's Emergency and Trauma Center, where she collaborated with nursing staff, physicians and other disciplines to attain positive patient outcomes. Previously, while working as a paramedic instructor at the Los Angeles County Department of Health Services Paramedic Training Institute, she assisted in the development of a continuing education course in pediatric education for the Los Angeles County Fire Department.*

YOU MAKE THE CALL

by Captain Steve Swiatek



The tones go off, the engine responds and firefighters assist their patient to the ambulance. We do it every hour of every day and to the best of our ability. But from time to time, and regardless of how well the duty is performed, a firefighter receives a subpoena to appear in court. This edition of the **PULSE** delves into **DOCUMENTATION –** that component of any EMS run that explicitly defines the level of patient care provided; and then asks the question, how would ***YOU MAKE THE CALL?***

The engine and squad took its turn backing into the station on that warm summer's night. "That makes 12," the engineer said as he set the maxi brake. The station had just completed a run involving a single vehicle accident. A 52-year-old man and his 60-year-old neighbor were returning from a Kings Hockey game. The driver was executing his final turn before home, when a coyote darted through the intersection. In swerving to miss the animal, the man sealed their fate to a frontal collision with a power pole. As units pulled up on scene, they witnessed the driver opening his door and exiting the pickup truck. "We'll take the driver," the paramedic stated to the captain as he walked by; and with that the two teams went to work.

The full sized pick-up truck had struck the pole at the passenger's headlight. The right fender and the hood were slightly buckled, and the corner of the passenger's windshield had a lone crack running from bottom to top. The passenger's door took some effort, but was opened without tools; there was no passenger space intrusion. Upon completion of the initial assessments, the firefighters found both patients to be alert and oriented times three, with each crew invoking spinal manual

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DocTalk

FROM MEDICAL DIRECTOR FRANKLIN D. PRATT, M.D.

Emergency medical services has always followed the lead of change in the medical community. In medicine today the brain is the organ that seems to attract substantial interest. This is manifested in emergency medical services by the Fast Mag program and what will soon be a system of a stroke centers in Los Angeles County. These two programs are the foundation of my column in this edition of The Pulse.

The Fast Mag Study is well past the halfway point; our own Squad 30 treated the patient that marked that point. This study, looking at whether the very early administration of intravenous magnesium can save brain cells, is a landmark study that has the potential to revolutionize care of the acute stroke patient. Emergency medical services involvement in this study allowed it to occur and will help further establish EMS as a vital player in the American health care system.

Our paramedic's ability to accurately and quickly identify the patient having a stroke is the key to the success of the Fast Mag Study. We have learned:

1. The patient with the sudden onset of trouble speaking, or weakness and paralysis on one side of the body, is well identified by EMS personnel.
2. The patient who presents with a change in their level of responsiveness or seems confused or agitated is frequently not thought to be a stroke patient. Their medical condition is attributed to other causes. This patient needs the complete Modified Los Angeles Prehospital Stroke Screen (mLAPSS).
3. Another group of patients underrepresented in the Fast Mag Study are patients with a right hemispheric stroke. The explanation below from the American Stroke Association details why patients can fool us sometimes. The patient denies all symptoms, despite their inability to perform certain tasks. Because the patient denies the symptoms, we omit the detailed exam.

"The right hemisphere of the brain controls the movement of the left side of the body. It also controls analytical and perceptual tasks, such as judging distance, size, speed, or position and seeing how parts are connected to wholes.

A stroke in the right hemisphere often causes paralysis in the left side of the body. This is known as left hemiplegia. Survivors of right-hemisphere strokes may also have problems with their spatial and perceptual abilities. This may cause them to misjudge distances (leading to a fall) or be unable to guide their hands to pick up an object, button a shirt or tie their shoes. They may even be unable to tell right-side up from upside-down when trying to read. These patients will "neglect" the left side of their body and not even think they have weakness or other problems. If you ask them whether they have any symptoms, they will deny it. Don't be fooled. Perform the complete exam – diagnose the stroke.

Because of our success with the Fast Mag Study, the medical and hospital community in Los Angeles County has started the move towards "stroke centers." Similar to STEMI Receiving Centers, these hospitals will be designated as special centers of excellence in the care of the stroke patient. If we assess a patient as having an acute stroke, we will transport the patient to one of these hospitals. These credentialed facilities will have the staff, equipment and treatment protocols in place to offer the best available care to the stroke patient. The criteria for taking a patient directly to a stroke center are specific and will only apply to a small number of acute stroke patients:

a. Symptom duration less than two hours
b. No history of seizures or epilepsy
c. Age greater than or equal to 40 years
d. At baseline, patient is not wheelchair bound or bedridden
e. Blood glucose between 60 and 400 mg/dl.
f. Motor Exam: Examine for obvious asymmetry-unilateral weakness (exam is positive if one or more of the following are noted to be asymmetrical):
    i. Facial Smile/Grimace
    ii. Grip
    iii. Arm Strength

As the prehospital assessment and treatment of these patients becomes more advanced, maybe it will be time to remove the phrase "altered" as the abbreviation for "altered level of consciousness" from the vocabulary of EMS. After 35 years in emergency medicine- related activities, I still can't figure what "altered" means. This word lacks the precision necessary in the future to give stroke patients and patients with behavioral changes the best care possible. We will describe the patient as "confused," "agitated," "less responsive to verbal or physical stimulus" or with another precise word. More to follow on this.

Thank you to everyone working for and with our Fire Department who provides "safety-net" medical and social services everyday to those in need in our County. Sometimes we are asked to do a lot with a little and go above and beyond the traditional role of the fire service – we do it well. I applaud your continued willingness to put the safety and comfort of others above your own safety and comfort. As always, contact me directly for any comments or questions at drpratt@fire.lacounty.gov.

Why is Documentation Important?

by Liz Budek

The old saying, "If it's not documented, it wasn't done," is a gold standard. You might be shrugging and thinking, "I've heard that before." But your response shouldn't stop there…your response should be followed with action. What action you say? EXCELLENT documentation.

Poor documentation -- or no documentation -- of a sequence of events doesn't necessarily mean care wasn't provided or provided inappropriately, but what the law expects and an expected standard of care is to have complete and concise documentation on the Patient Care Record (PCR). The law also expects care providers to maintain standards of care comparable to those of similar providers.

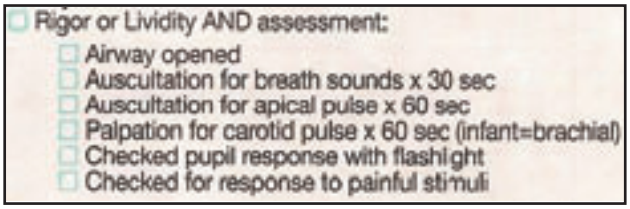
Documentation must be accurate, timely, and reflective of the patient's condition and responses. The emphasis of documentation is on significant findings, including pertinent negative and positive findings, or exceptions to a patient's baseline as related to the patient's chief complaint or presenting illness and their response to treatment. EMS personnel should be familiar with Departmental and regulatory agency policies, procedures and requirements regarding documentation.

The PCR also serves as a legal document and may be used in support of the Department and staff or to defend against legal action. The PCR is a diary of the patient's encounter, a story of what happened to the patient and the sequence of events.

Omitting pertinent information or documenting poorly or incorrectly places you and the Department at risk and prevents the communication of patient information to other health care providers rendering care to them. Risk is defined as potential loss, meaning an exposure to liability. EMS personnel must be aware of their responsibility in controlling loss.

There are several ways you can improve documentation and several things you can do to assist in risk management when it comes to documentation:

1. Consider the legal implications of what you do as a licensed professional
   a. Ensure that you comply with policies and procedures
   b. Practice within your scope of practice
2. Document correctly and responsibly
   a. Use one EMS report form for each patient
      i. The Sequence Number is the only unique patient identifier.
      ii. Complete all sections of the EMS report form, including but not limited to, sex, age (in years, months, weeks or days as appropriate), run type, correct provider code, second sequence number (when applicable), destination and rationale for destination, correct chief complaint code, time and response to medications and/or treatment, etc. These were some of the deficiencies identified in documentation during our most recent audit by the LA County EMS Agency.
   b. Write down your observations and actions
      i. Describe any difficulties encountered en route and during patient treatment, extrication and transport.
      ii. Use quotation marks to identify patient or bystander comments.
      iii. Ensure to follow documentation policy requirements. For example, ensure documentation requirement criteria are completed when determining death due to lividity and/or rigor mortis only, such as:
         1. Auscultation for breath sounds x 30 seconds
         2. Auscultated for apical pulse x 60 seconds
         3. Palpation for carotid pulse x 60 seconds
         4. Checked pupil response with flashlight
         5. Checked for response to painful stimuli



This can be done by checking off the preprinted boxes on the back of the form (much easier, less writing required) or by writing it in the narrative. This deficiency was identified while reviewing CA runs. Note: Documenting "Meets 814 criteria" is not sufficient.

   c. Write legibly
      i. PCRs may be subpoenaed years after an incident. The illegibility of important facts may severely hurt the case of an employee or a department.
      ii. Illegible notations cause difficulty and delays when verifying scanned data
      iii. Spell all words correctly
      iv. Do not use slang terms
   d. Use only approved abbreviations

So, how can we put all this together and explain the risks and benefits to you and the Department of complete and concise documentation? The answers to the two questions below are a good start.

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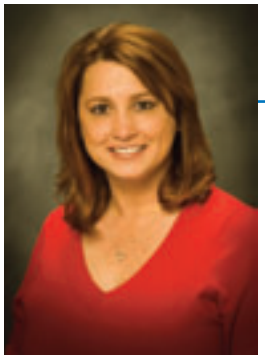

Risk Management: How does it apply in EMS?

By Victoria Hernandez, RN, BCN, MICN

Over the years, EMS has become an integral part of the healthcare system. We are providing more services to the patient than ever before. Anytime a person dials 911, they expect a certain amount of services and response for themselves or their loved ones. It is our responsibility to provide that service and ensure that all steps are done to provide the highest level of care possible to the patient. The Los Angeles County Fire Department Patient Care Guidelines state that all patients should be treated as if they were members of our own family. In addition, it is the expectation that anytime 911 is dialed, each call will be handled quickly, safely and appropriately.

This is when the concept of risk management comes to the forefront. Although is not one of our first thoughts when we hear the tones sound off for the next call, it should be in the back of our minds at all times.

Risk management is defined in several ways but let's start with the basics. The word "risk" can be defined as the possibility of meeting danger, suffering harm or loss or the exposure to harm or loss; "management" is how we deal with the identified risk. In simpler terms, *risk management* refers to the identification, investigation, analysis, evaluation and hopefully the reduction of risk within an organization.

With that in mind, how does this relate to EMS? The first step would be to understand some of the concepts that are related to determining the possibility of risk. These concepts are (a) looking at the probability that an event may occur; (b) an unwarranted or undesirable outcome of an event; (c) the severity of the potential harm of the event and (d) the presence of negligence.

Negligence can be defined as the failure to exercise a degree of care considered reasonable under the circumstances and results in some type of unintended injury to the patient. This occurs when there is a proven duty to act or a standard of care exists (such as the Los Angeles County Pre-hospital Care Policy Manual and the Los Angeles County Fire Department Patient Care Guidelines), and there has been a failure to conform or act to the established standard. It can also be defined as a direct link that shows a failure to act as the cause of an actual loss or injury to the patient that is measurable.

Two concepts should be evaluated when identifying possibilities of risk and/or risk management. They are the level of risk and the level of frequency that these events occur. There are events that are high frequency but are still low risk, such as applying bandages to wounds. They are done pretty frequently and do not usually have serious complications. Then there are those events that are low in frequency but still have a relatively low risk factor, such as applying a basic splint. However, there are those events that are high frequency, high risk, such as driving code three to an incident or fire. Finally, there are events that are

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Why is Documentation Important?

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EMS Report Forms

What happens when it is filled out poorly or incorrectly?

You and the Department are placed at "RISK."

What happens when it is filled out correctly?

- Provide the first link in continuity of patient care as accurate patient information is communicated to other health care providers rendering care.
- Provide protection from legal actions by providing the primary foundation for your defense.
- Represent yourself and the Department as exemplars interdepartmentally and to the regulating agency.

Firefighters fill out the run sheet on a call.

- Create revenue for the Department by providing accurate and timely information required for billing.
- Assist the Quality Improvement (QI) Program to provide good data to identify system issues, which may result in policy and/or procedure changes to improve patient care.
- Identify training needs, thus provide QI-based education.
- Provide the opportunity for research, as data collection is an integral component of all research projects.

The information incorporated in this article is not all inclusive of documentation requirements. Documentation requirements are difficult to summarize in a few paragraphs, so it will continue to be explored in the next edition of *The Pulse*.

Risk Management: How does it apply to EMS?

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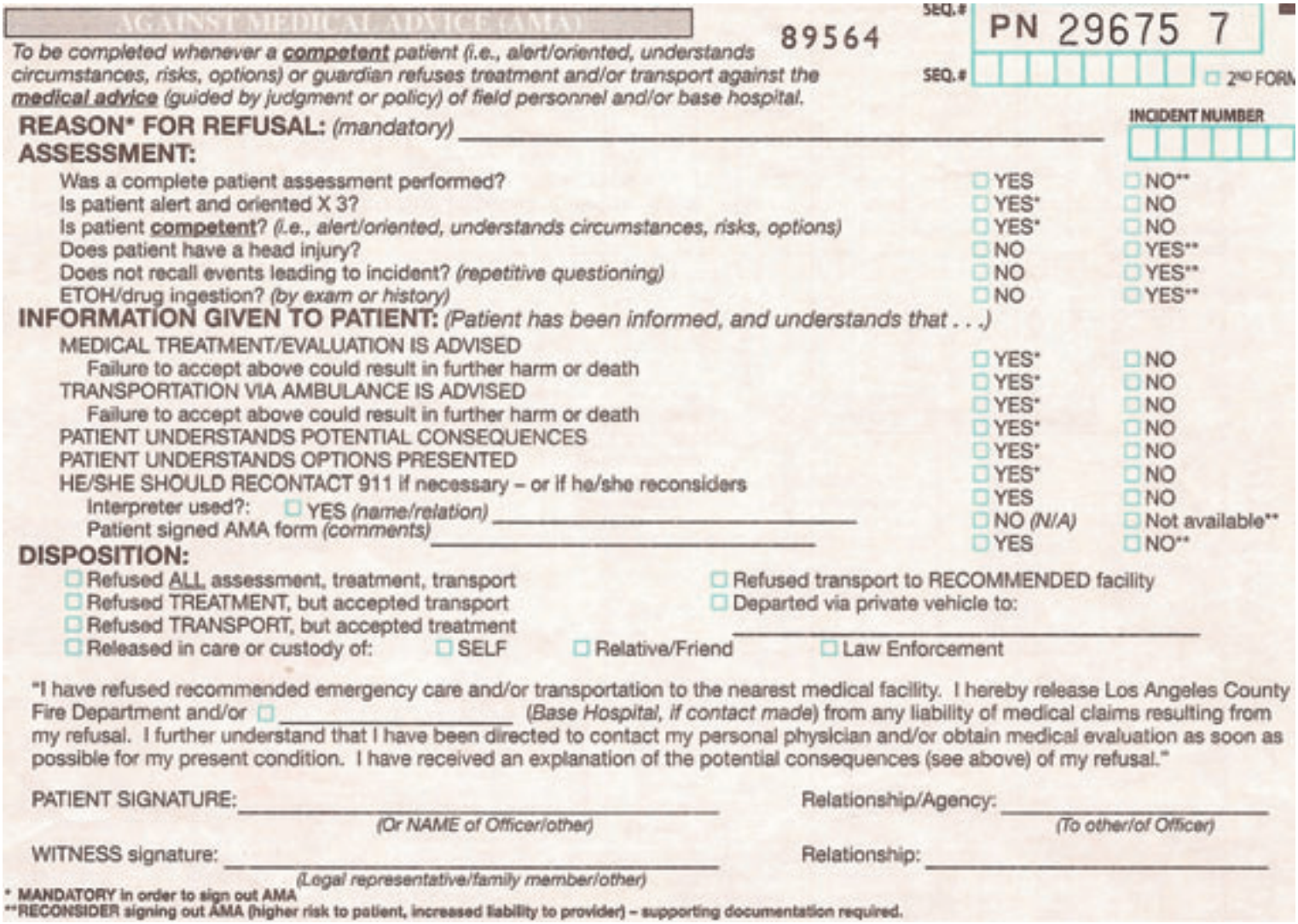

AGAINST MEDICAL ADVICE (AMA) 89564

SEQ.# PN 29675 7

SEQ.# ☐ 2ND FORM

*To be completed whenever a **competent** patient (i.e., alert/oriented, understands circumstances, risks, options) or guardian refuses treatment and/or transport against the **medical advice** (guided by judgment or policy) of field personnel and/or base hospital.*

INCIDENT NUMBER

REASON* FOR REFUSAL: *(mandatory)* _____

ASSESSMENT:

Was a complete patient assessment performed?	☐ YES	☐ NO**
Is patient alert and oriented X 3?	☐ YES*	☐ NO
Is patient **competent**? *(i.e., alert/oriented, understands circumstances, risks, options)*	☐ YES*	☐ NO
Does patient have a head injury?	☐ NO	☐ YES**
Does not recall events leading to incident? *(repetitive questioning)*	☐ NO	☐ YES**
ETOH/drug ingestion? *(by exam or history)*	☐ NO	☐ YES**

INFORMATION GIVEN TO PATIENT: *(Patient has been informed, and understands that . . .)*

MEDICAL TREATMENT/EVALUATION IS ADVISED	☐ YES*	☐ NO
Failure to accept above could result in further harm or death	☐ YES*	☐ NO
TRANSPORTATION VIA AMBULANCE IS ADVISED	☐ YES*	☐ NO
Failure to accept above could result in further harm or death	☐ YES*	☐ NO
PATIENT UNDERSTANDS POTENTIAL CONSEQUENCES	☐ YES*	☐ NO
PATIENT UNDERSTANDS OPTIONS PRESENTED	☐ YES*	☐ NO
HE/SHE SHOULD RECONTACT 911 if necessary – or if he/she reconsiders	☐ YES	☐ NO
Interpreter used?: ☐ YES *(name/relation)* _____	☐ NO *(N/A)*	☐ Not available**
Patient signed AMA form *(comments)* _____	☐ YES	☐ NO**

DISPOSITION:

☐ Refused ALL assessment, treatment, transport
☐ Refused TREATMENT, but accepted transport
☐ Refused TRANSPORT, but accepted treatment
☐ Released in care or custody of: ☐ SELF ☐ Relative/Friend ☐ Law Enforcement

☐ Refused transport to RECOMMENDED facility
☐ Departed via private vehicle to: _____

"I have refused recommended emergency care and/or transportation to the nearest medical facility. I hereby release Los Angeles County Fire Department and/or ☐ _____ *(Base Hospital, if contact made)* from any liability of medical claims resulting from my refusal. I further understand that I have been directed to contact my personal physician and/or obtain medical evaluation as soon as possible for my present condition. I have received an explanation of the potential consequences (see above) of my refusal."

PATIENT SIGNATURE: _____ *(Or NAME of Officer/other)*

Relationship/Agency: _____ *(To other/of Officer)*

WITNESS signature: _____ *(Legal representative/family member/other)*

Relationship: _____

* MANDATORY in order to sign out AMA
**RECONSIDER signing out AMA (higher risk to patient, increased liability to provider) – supporting documentation required.

low frequency but high risk such as signing a patient out against medical advice (AMA) which can lead to serious consequences if not done and documented appropriately. More often than not, this type of event is more likely to get a prehospital care provider in the most amount of trouble.

So how can a prehospital care provider protect themselves from these incidents that carry a lot of risk and have the potential for litigation? Documentation and the adherence to established policies, procedures and standards of care. Los Angeles County Fire Department Patient Care Guidelines and the Los Angeles County Prehospital Care Policy Manual were developed to provide guidelines and protocols for the prehospital care provider. At the same time, these are the standards of care to which we are held to every day while providing care to the public. Documentation of care is written on the patient care record (PCR), or EMS report form, and is therefore considered a part of the medical record. It has been said over and over again that if a procedure is not documented; it wasn't done. The incomplete PCR is routinely used in a court of law to disprove the quality of care delivered to the patient. In the case of AMAs, complete and appropriate documentation is essential to protect an individual from the possibility of litigation. Details such as whether the patient is competent, under the influence of alcohol or has an altered mental status should be taken into consideration before a person is allowed to sign out AMA. To further assist you, the back of page one of the EMS report has a checklist area to document that these areas were addressed (pictured).

The EMS system is inherently filled with a variety of risks. In order to better manage these risks, there must be some sort of process to identify and minimize them. Properly applied risk management strategies can benefit the prehospital care provider and minimize any financial losses associated with bad outcomes.

YOU MAKE THE CALL

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stabilization. The driver complained of pain in his neck and left shoulder, as well as in his left knee. The passenger described how his wrist hurt from bracing for the impact. Upon further probing, he also described lower back and right ankle pain. No neurological deficits were found in either patient. With the rapid trauma assessments completed the firefighters, with the assistance of the ambulance crew, initiated the appropriate standing and seated spinal immobilization technique for each patient. As fortune sometimes presents itself, a second ambulance happened to be driving by and stopped to see if additional aid was needed. This timely arrival provided a gurney for each patient and a platform for the focused history and secondary physical examination to be completed. The patient's vitals were within normal ranges, and upon physical examination, no evidence of obvious trauma was noted. "Any trauma criteria or guideline?" the paramedic asked the captain. "None found here; BLS transport is what I'm figuring," he said. With that, the paramedic and captain focused on completing the documentation for each patient. As the paramedic climbed out of one of the ambulances, the captain walked up and handed his clipboard to the paramedic. "Look OK to you?" he asked. The paramedic took a moment to review what the captain had written and stated, "Looks fine to me, Cap." With the appropriate sheets ripped out, the ambulance doors were closed. An everyday call with a typical write up, so how would ***YOU MAKE THE CALL??***

"If it's not written, it was never performed." When it comes to documentation, it's the one phrase heard since becoming an EMT, and the paramount statement drilled into every paramedic trainee. From shooting to tazing, from train derailments to auto accidents, obvious reasons for sound documentation are graphically detailed on television every day.

In today's videographic and litigious society, sound stand alone documentation is that single component of an EMS call that will demonstrate to its reader the provider's attempt to impart the best possible care for the patient. Be it medical or trauma, the "pertinent positives and negatives" not only need to be determined but demand to be written. With dramatic clarity, a paramedic recently stated, "Good sound documentation does not preclude one from ever receiving a subpoena!" That statement was also resonated by a risk management specialist when describing how an attorney dissected an EMS report in court. "The report," he began, "was enlarged to three by four feet and mounted on an easel. Then line by line the lawyer reviewed the entire report with the witness and the jury." In dramatic detail, the lawyer scrutinized those elements of the EMS report completed by the paramedic and sensationalized that which was missing or lacking. "When lecturing to firefighters and EMS providers," the specialist concluded, "I leave them with a final thought. The way you provide care and document your findings is also the way you protect your license and ultimately your career…think about it!"

Just completing another run, the paramedics walked into the kitchen as dinner hit the table. "How did it go?" the captain inquired. "When we dropped off the last patient," the paramedic began, "we asked how the accident patients were getting along. We were told the driver had two cervical fractures!" The captain looked up from the table and asked "How did you guys write him up?" The two paramedics looked at each other, then one said; "Well we reviewed the run sheet and we…….!

So take a few minutes, and review the last five EMS reports your station prepared; then reflect on a statement made by a seasoned paramedic: "From hangnail to multiple shooting, the same amount of detail, the same sound documentation needs to always be performed." Then answer the question: How did ***YOU MAKE THE CALL?***

THE PULSE

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EMS NEWS BRIEFS

By ROBERT JAMIESON, R.N., Senior Nursing Instructor

CONTINUING EDUCATION

EMS Update starts this month – remember it is mandatory for paramedics. It is still OK to take it at the base hospitals.

EQUIPMENT ISSUES

1. Remember that drugs do not go down the ET anymore.
2. When all 10mg of either Valium or Morphine are used, then a signature from an R.N. at the hospital *is not required* – a signature is only required for a waste.
3. The new King LTSD airway will be introduced at EMS Update to replace the Combi-tube, which will be phased out through attrition.
4. No official word yet on which monitor/defibrillator the Department is going with, but they will have NIBP (non-invasive blood pressure monitoring). It is not known if there will be mandatory in servicing of the new units for all paramedics.
5. Please remember that you may need to dilute medications when administering to pediatric patients – it would not be practical to do fractional doses with concentrated medications through a tuberculin syringe.
6. There have been questions about downloading the AED after usage. An electronic download is required when used; we do not need to send any paperwork.

PATIENT CARE QUESTIONS & ANSWERS

1. When documenting on the EMS Report, all patients with rigor and/or lividity need to have the specific information addressed (it is not acceptable to just write "per Ref. 814."):
   a. Open the airway
   b. Auscultation of breath sounds – 30 seconds
   c. Auscultation for apical pulse – 60 seconds
   d. Palpation for carotid pulse – 60 seconds (infant = brachial)
   e. Assessment of Neurological Reflexes (pupils and painful stimuli)
2. When documenting on the EMS Report form, traumatic arrests are not coded as a "CA", but as either "BT" (blunt arrest) or "PT" (penetrating arrest).
3. From what I am hearing and seeing, there has been an increase in medicating patients in pain with morphine. There have been studies showing that patients medicated early on have a shorter hospital stay and less long term pain issues. I realize that our process of re-supply is complex, but this is one of the things that truly makes a difference in what we do. **Thanks for all of your hard work.**

EMS in Action

Golden Guardian '08 – East Region Multi-casualty Drill at Miller Brewing Comapny.

T.C.T. – Person Trapped, 210 Freeway in Division II

Squad 50 – Heavy Rescue Inventory